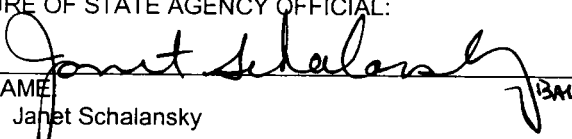
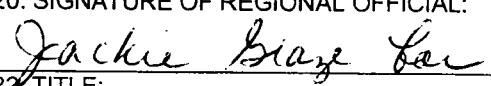


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL HEALTHCARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: SPA #02-08	2. STATE: Kansas
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2002	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.12		7. FEDERAL BUDGET IMPACT a. FFY <u>2002</u> \$ <u>0</u> b. FFY <u>2003</u> \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B #2.b., Pages 1-10		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B #4.b., Pages 1-8	
10. SUBJECT OF AMENDMENT: Federally Qualified Health Centers - Methods & Standards for Establishing Payment Rates			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Janet Schalansky is the Governor's <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Designee			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Janet Schalansky, Secretary Social & Rehabilitation Services Docking State Office Building 915 SW Harrison, Room 651S Topeka, KS 66612-2210	
13. TYPED NAME: Janet Schalansky			
14. TITLE: Secretary			
15. DATE SUBMITTED: 03/21/02			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 03/22/02		18. DATE APPROVED: JUN 20 2002	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/02		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Thomas W. Lenz		22. TITLE: ARA for Medicaid & State Operations	
23. REMARKS: CCV Schalansky Day/Haverkamp CO DSG/DIATA SPA CONTROL Date Submitted: 03/21/02 Date Received: 03/22/02			

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Effective January 1, 2001, Federally qualified health centers enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An FQHC shall be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare plus dental services shall be made through an all-inclusive encounter rate determined by the agency for each qualified visit.

When a federally qualified health center furnishes "other ambulatory services" excluding dental services, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all requirements under the state plan are met. "Other ambulatory services" are those which do not meet the Medicare definition of federally qualified health center services, but are covered under the Medicaid state plan.

I. ENCOUNTER BILLING

The federally qualified health center program under the Kansas Medicaid Program complies with scope, definitions, criteria, and basis of payment for FQHC services under Medicare set forth in 42 CFR Part 405.2411 and 405.2446 through 405.2452, and Publication 27.

A. Billable Visit or Encounter

A federally qualified health center "visit" means a face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), nurse-midwife, dentist, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health professional or multiple encounters with the same practitioner on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional FQHC visit.

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- (ii) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of resident as a result of a medical or health condition;
- (iii) the "place of resident" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;
- (iv) the services are furnished by a registered nurse (RN) or licensed practical nurse (LPN) who is employed by or receives compensation for providing these services from the FQHC;
- (v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the center which is
 - reviewed at least every 60 days by a supervising physician, and
 - signed by a supervising physician, ARNP, or PA of the center;
- (vi) the services consist of:
 - nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
 - personal care services to the extent covered under home health services.

This does not include household and housekeeping services.

E. Content-of-Service

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as an FQHC encounter nor as a service under any other Medicaid provider number.

Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the center that are "incident to" the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a center health care professional.
4. Drugs and biologicals which cannot be self-administered.

F. Exclusions

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis &

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treatment of center patients are not covered. These should neither be billed as FQHC visits nor reported on the cost report as allowable FQHC expenditure. In addition, the following are not covered as FQHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the center.
2. Services provided by the FQHC's auxiliary health care employees without direct supervision of a center practitioner.
3. Technical components of Radiology and EKG.
4. Clinical diagnostic laboratory services.
5. Health care services **performed by** outside entities, including those entities which are owned by the center's owner(s) or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The State Plan requires that providers of these services bill Medicaid directly.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS) for federally qualified health centers to conform with BIPA 2000. There will be no retroactive cost settlements under this system. As an alternative to the PPS, providers will be offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, FQHCs will be paid the greater of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system for the duration of a specific facility fiscal year, providers will be required to submit written requests on a timely basis according to the schedule outlined in II.B.

A. Definitions

1. **Rate** - Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 - Current Providers** - Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 - New Providers** - Two facility fiscal years subsequent to the first year of business as a federally qualified health center.
4. **Cost-Based Rate or Payment** - Based on reasonable cost of covered services.

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5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derived from unaudited cost report(s) or from only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.

B. Criteria for Election of the Alternative Payment Option

1. **For Facility Fiscal Years Beginning Prior to October 1, 2001** - The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time
2. **For Facility Fiscal Years Beginning On or After October 1, 2001** - The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
3. **No Request Received** - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

C. Cost Reports

Each provider shall be required to submit a federally qualified health center cost report on facility fiscal year basis using the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. Non-reimbursable costs shall be reported in the appropriate sections of the cost report and shall not be co-mingled with allowable costs. All space, equipment, personnel and other expenses associated with laboratory services shall be separated from allowable FQHC expenses, and reported as a separate cost center in the non-FQHC or non-reimbursable section.

The cost report should be supplemented by a detailed trial balance which includes cost report line numbers for cross-checking, independent auditor's report & management letter, an itemized list of revenue including source & purpose, and any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements. Support for all information must be available for review.

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D. Determination of Cost-Based Rate

- 1. Total Reasonable Cost:** Total allowable cost of FQHC core services and dental services, after overhead allocation and revenue offsets, as described in section V.
- 2. Adjusted Total Visits:** Actual visits shall be adjusted by applying a minimum productivity standard of 4,200 hours for Physicians and 2,100 hours for PA, ARNP, and Dentist.
- 3. Cost-based Encounter Rate:** Total reasonable cost divided by adjusted total visits.

III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, FQHCs shall be paid prospective rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

A. Determination of PPS Baseline Rate

- 1. Methodology** - It will depend on the time frames covered by an availability of cost reports as follows:
 - (i) Both Base Years Full Twelve-Month Periods:
 $(\text{FY 1 Cost-Based Rate} + \text{FY 2 Cost-Based Rate}) / 2.$
 - (ii) One or Both Base Years Less Than Twelve-Month Periods:
 $[(\text{FY 1 Cost-Based Rate} \times \text{No. of Mo.}) + (\text{FY 2 Cost-Based Rate} \times \text{No. of Mo.})] / \text{Total No. of Months}$
 - (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
 - (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce. The rates will be adjusted for dental services (not provided by all FQHCs).
- 2. Frequency** - Once if *audited* cost reports from *both* base years are available at the time of initial rate setting, otherwise twice:
 - (i) Initial Baseline Rate: After the approval of the state plan amendment (for current providers) or at the time of enrollment (for new providers). Initial rate can be preliminary or finalized.
 - (ii) Final Baseline Rate: When audited cost reports for both base years become available.

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B. Payment Procedure for January 1, 2001 to September 30, 2001

1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.
3. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
4. In cases where the initial baseline rate is "preliminary", interim payments will again be retroactively reconciled to the "final" baseline rate when available.

C. Payment Procedure for October 1, 2001 to September 30, 2002

1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
2. In cases where the baseline rates used for this rate setting are "preliminary", when "final" baseline rates are available they will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

D. Payment Rate Effective Each October 1 After September 30, 2002

1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
2. In cases where the baseline rate used for this rate setting is "preliminary", when the "final" baseline rate becomes available it will be adjust by MEI index to yield a finalized P.P.S. rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

E. Baseline Rate for New Providers

1. **If Historic Cost Reports Are Available:** If the facility is an established FQHC, historic data from cost reports of the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting provided it is at least a twelve-month period. Data covering the first year of business as an FQHC will be excluded.
2. **If No Historic Data Exists, But FQHC Submits Budget on FQHC Cost Report Form:** If the facility is not an already established FQHC, the rate may be derived from a budget submitted by the enrollee.

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C. Payment Rates Effective Each October 1 After September 30, 2002

The PPS rates effective on the previous day (September 30 of the same year) adjusted for the MEI index.

D. Retroactive Cost Settlement

1. **Cost-Based Medicaid Cost:** It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate determined from the cost report to total covered Medicaid visits obtained from the fiscal agent records.
2. **PPS-Based Medicaid Cost:** It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.
3. **Total Payment Received by Provider:** It consists of Medicaid payment, third party liability, and HealthConnect payments obtained from fiscal agent records; and any other related transaction.
4. **Overpayment or (Underpayment):** The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

V. DETERMINATION OF REASONABLE COST

Reasonable cost consists of necessary and proper cost incurred in providing covered federally qualified health center services and dental services to all patients. Cost reimbursement principles, productivity screens, other limits, and coverage criteria set forth in K.A.R. 30-5-118, K.A.R. 30-5-118a, K.A.R. 30-5-118b, 42 CFR Part 405.2411 and 405.2446 through 405.2452, Medicaid state plan, Medicaid provider manual, 42 CFR Part 413, and Medicare Publications 10 & 27 shall be applied to the data submitted to Medicaid as tests of reasonableness.

A. Review & Analysis of Reported Data

Expenditures & income reported to Medicaid will be reconciled with the trial balance, financial statements prepared by the independent auditor, and the finalized Medicare cost report. Expenses reported as allowable, including overhead cost, will be analyzed to evaluate if they are accurate, reasonable, necessary, patient related, associated with covered services, and reported in appropriate cost centers. Revenue will be analyzed for

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refunds received. Any findings will be deducted from reported expenses to yield total allowable cost. The encounter data will be analyzed for reasonableness, accuracy, inclusion of nursing assessments, and visits not meeting the definition of billable visits.

B. Revenue Offsets

Income will also be analyzed to confirm that Medicaid payments do not duplicate revenue received from other sources to cover specific programs or expenses, whether in part or whole. If such duplication is found, it will be offset before rate calculation.

NOTE: Public Health Service Grants under section 329, 330, and 340 shall not be offset against expenses in determining allowable cost. To prevent such offset, the provider shall clearly identify these grants by name, not just numbers, in the supplemental data submitted with the cost report.

C. Total Reasonable FQHC & Dental Cost for the Facility

Allowable overhead (indirect) expense will be allocated to total allowable FQHC & Dental (direct) costs and total non-reimbursable (direct) expenses based on the proportion of each "direct" cost center to their summation. Post-allocation total FQHC & Dental expenses minus any revenue offsets shall be the total reasonable cost of covered FQHC and Dental services furnished to all patients, regardless of payer.

VI. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a FQHC elects the alternative reimbursement option for a given fiscal year, it will be eligible for a settlement on covered services provided during that time period to eligible Medicaid beneficiaries under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the FQHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified Cost-Based System (CBS), for the elected fiscal year.

A. Quarterly Supplemental Payments

The FQHC must send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "FQHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The

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state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the FQHC no more than 90 days from the receipt of the remittance advices.

B. Fiscal Year End Settlement

When a *fiscal* year end final retroactive cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during the same fiscal year. A "yearly alternative amount" will be computed using total encounters for that time period obtained from the supplemental payment data and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed alternative amount for the year is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the yearly alternative amount is lower than total payments, the FQHC shall refund the overpayment to the agency.

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